PRIMARY CARE PAYMENT MODEL INTRODUCTION

INTRODUCTION

The healthcare landscape continues to rapidly evolve, placing increased focus and demand on paying for value, not volume. This increased demand requires clinics to innovate the ways in which they deliver care and continually transform their practices into high performing Patient Centered Primary Care Homes (PCPCH). The Primary Care Payment Model (PCPM) is designed to support clinics in making this transition and in achieving the triple aim.

PCPM Track 1:

PCPM Track 1 is an introductory alternative payment program that aims to support PCPCHs in building capacity for population health management in order to advance team-based care, and to develop infrastructure to promote a culture of data-driven improvement. Successful participation in PCPM Track 1 requires:

1. Continuous quality improvement processes for five (5) self-selected quality measures from the PCPM Track 1 Quality Measure Set.
2. Accurate reporting of standardized quality measures on a rolling 12-month time period.
3. Demonstration of improvement in measure performance across entire PCPCH population (all payers).

PCPM Track 2:

PCPM Track 2 is a more advanced alternative payment program which rewards clinics that achieve high quality performance across multiple care areas. PCPM Track 2 encourages clinics to advance their data reporting capabilities and align with Medicare and State Medicaid quality and cost priorities. Successful participation in PCPM Track 2 requires:

1. Accurate reporting of CareOregon member-level data on measure sets and timeframes defined by PCPM Track 2.
2. Demonstration of high quality care through achievement of measure benchmarks.

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PRIMARY CARE PAYMENT MODEL TRACK 1

PCPM TRACK 1

General Eligibility Requirements

Eligibility requirements must be met at the time of PCPM Application deadline.

1. Oregon PCPCH recognition of Tier Three (3) or above.
2. Minimum total CareOregon membership assigned to system (all PCPCH clinics combined):
    a. CareOregon Metro: ≥ 500 CareOregon members
    b. Columbia Pacific: ≥ 250 CareOregon members
    c. Jackson Care Connect: ≥ 250 CareOregon members
3. Clinic must be able to report rolling 12-month data for entire patient population.

Application Process

1. Clinic submits PCPM application including all required information for each PCPCH.
    a. Provide PCPCH clinic and contact information.
    b. Complete all required fields.
    c. Select five (5) measures on which to report from the PCPM Track 1 Clinical Quality Measure Set.
2. Application deadlines are specified for each region in Table 1.
3. Payment commencement is dependent on timing of Letter of Agreement (LOA) execution.

Program Model

1. Approved PCPCH clinics receive a risk-adjusted per member per month (PMPM) Quality Incentive Payment for assigned members where the primary coverage is CareOregon.
    a. PCPCH clinics new to participation in PCPM Track 1, are initiated at Payment Level One (1).
    b. PCPCH clinics currently participating in PCPM Track 1 will continue at current Payment Level.
    c. Actual PMPM rates are risk-adjusted up or down from PCPM Track 1 Model PMPM rates in Table 3.
2. Clinic reports on five (5) self-selected measures from the PCPM Track 1 Clinical Quality Measure Set.
    a. All measurement data must reflect entire patient population.
    b. All measurement data must be submitted using rolling 12-month methodology (Example on Table 4).
    c. Reporting deliverable deadlines are specified in Table 2
3. PMPM Quality Incentive Payment Level is determined and adjusted based on timely and successful reporting, and performance on selected measures.

Deliverable Schedules & Program Model

Table 1: PCPM Track 1 Application and LOA Schedule

APM Program	Application Deadline	LOA Deadline	LOA Effective Dates
All Regions PCPM Track 1	February 28, 2019	May 31, 2019	July 1, 2019 – June 30, 2020

Table 2: PCPM Track 1 Reporting and Payment Adjustment Schedule

LOA Effective Dates	Data Submission Deadline	Reporting Period (Rolling 12-months)	Improvement Target	Payment Adjustment Date
Metro PCPM Track 1 July 1, 2019 – June 30, 2020	August 31, 2019	April 2019 – June 2019*	1.5%*	December 2019
	February 29, 2020	July 2019 – December 2019	3.0%	June 2020
JCC PCPM Track 1 July 1, 2019 – June 30, 2020	August 31, 2019	January 2019 – June 2019	3.0%	December 2019
	February 29, 2020	July 2019 – December 2019	3.0%	June 2020
CPCCO PCPM Track 1 *(LOA terming June 30, 2019)* July 1, 2019 – June 30, 2020	August 31, 2019	January 2019 – June 2019	3.0%	December 2019
	February 29, 2020	July 2019 – December 2019	3.0%	June 2020

**Improvement target is adjusted for abbreviated 3-month reporting period.*

Table 3: PCPM Track 1 Program Model

Payment Level 0	
Data not submitted by deadline.	$0.00 PMPM
Payment Level 1	
≥ 3.0%* improvement on **0** measures	$1.00 PMPM**
Payment Level 2	
≥ 3.0%* improvement on **1-2** measures	$2.00 PMPM**
Payment Level 3	
≥ 3.0%* improvement on **3-5** measures	$4.00 PMPM**

**Improvement target is adjusted to 1.5% for abbreviated 3-month reporting periods.*

***Actual Clinical Quality Incentive Payment PMPM rates may be risk-adjusted up or down from PCPM Track 1 Program Model PMPM rates in Table 3. The risk adjustment methodology is based on a combination of risk scores and rate codes used by OHA and CMS. This method uses both the Chronic Illness & Disability Payment System (CDPS) and Hierarchical Condition Category (HCC) risk models.*

Quality Measure Selection Requirements

1. Five (5) measures must be selected from the PCPM Track 1 Clinical Quality Measure Set for each participating PCPCH clinic.
    a. At least three (3) "Priority Measures" must be selected.
    b. Any measure may be selected for the remaining two (2) required measures.
2. All selected Quality Measures must include at least 30 patients in the denominator, using aggregated Provider system data.
3. Clinics are strongly advised to review measure specifications and confer with data reporting team/vendor(s) prior to measure selection to ensure EMR capability to extract data to specifications.

Data Submission Requirements

1. Data must be submitted via the CareOregon data submission webpage.
2. Numerator and denominator values must be submitted for selected measures, for each month in the reporting period.
3. Data must be submitted using rolling 12-month methodology.
4. Data must be submitted for the entire patient population of each participating PCPCH (including other payors, self-pay, and uninsured).
5. Data must be submitted to specifications as indicated on the PCPM Track 1 Quality Measure Set. Incomplete, invalid, or erroneous data will be excluded from the Payment Level calculation until next Payment Adjustment Date.

Table 4: Example of Rolling 12-month Methodology

Reporting Month	Rolling 12-Month Reporting Period
July 2019	August 1, 2018 – July 31, 2019
August 2019	September 1, 2018 – August 31, 2019
September 2019	October 1, 2018 – September 30, 2019

PCPM Track 1 Clinical Quality Measure Set

To support the ongoing work of Coordinated Care Organizations and Medicare, these measures are aligned with both the State and Federal priority metrics.

Priority Measures – Select at least 3	Specification
Adolescent Well Care Visits	CCO Incentive
Alcohol & Drug Misuse (SBIRT 18+ & CRAFFT 12+)	CCO Incentive
Breast Cancer Screening	NQF 2372
Childhood Immunization Status (Combo 2)	CCO Incentive
Cigarette Smoking Prevalence (start at 13)	CCO Incentive
Controlling Blood Pressure	CCO Incentive
Colorectal Cancer Screening	CCO Incentive
Effective Contraception Use	CCO Incentive
Prenatal Care in First Trimester (Prenatal Only)	CCO Incentive
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents	CCO Incentive
Diabetes: Eye Exam	NQF 0055
Diabetes: Hemoglobin A1c Poor Control (% A1c > 9.0%)	CCO Incentive
Diabetes: Medical Attention for Nephropathy	NQF 0062
Other Measures:	**Specification**
Diabetes: Blood Pressure Management (% BP < 140/90)	NQF 0061
Diabetes: LDL Management and Control (% LDL < 100)	NQF 0064
Advanced care planning among patients 65+	NQF 0326
Cervical Cancer Screening	NQF 0032
Developmental Screening	CCO Incentive
Eligible population with a Flu Shot	NQF 0041
First Tooth Measure	TBD
Immunization for Adolescents (Combo 1)	CCO Incentive
Medication Review among patients 66+	NQF 0553
Screening for Depression and Follow up Plan	CCO Incentive
Use of Appropriate Asthma Meds	NQF 0036
Well-Child visits in the First 15 months of life (5+)	NQF 1392
% Patients with ED Visits Receiving a Follow Up Call	TBD

Clinics are strongly advised to review measure specifications and confer with data reporting team/vendor(s) prior to measure selection to ensure EMR capability to extract data to specifications.

More information on The Oregon Health Authority's CCO Incentive Metrics can be found using the link below:
https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

PRIMARY CARE PAYMENT MODEL TRACK 2

PCPM TRACK 2

General Eligibility Requirements

Eligibility requirements must be met at the time of PCPM Application deadline.

1. Oregon PCPCH recognition of Tier Four (4) or above.
2. Minimum total CareOregon membership assigned to system (all PCPCH clinics combined):
    a. CareOregon Metro: ≥ 500 CareOregon members
    b. Columbia Pacific: ≥ 500 CareOregon members
    c. Jackson Care Connect: ≥ 500 CareOregon members
3. Clinic must be able to report member-level data for assigned CareOregon membership.

Application Process

1. Clinic submits PCPM application including all required information for each PCPCH.
    a. Select appropriate Quality Measure Set for population: Internal Medicine, Family Practice, or Pediatric.
    b. Identify Quality Measures requiring substitution.
2. Application deadlines are specified for each region in Table 5.
3. Payment commencement is dependent on timing of Letter of Agreement (LOA) execution.

Program Model

There are two incentive payment components that comprise the PCPM Track 2 Program Model: The Quality Incentive Payment and the Cost of Care Incentive Payment.

1. Clinical Quality Incentive Payment:
    a. Approved PCPCH clinics receive a risk-adjusted per member per month (PMPM) Clinical Quality Incentive Payment for assigned members (Oregon Health Plan and Medicare) where the primary plan coverage is CareOregon.
        i. All PCPCH clinics new to participation in PCPM Track 2, are initiated at Payment Level One (1).
        ii. PCPCH clinics currently participating in PCPM Track 2, will continue at current Payment Level.
    b. Actual PMPM rates may be risk-adjusted up or down from Program Model PMPM rates in Table 7.
    c. Clinical Quality Incentive Payment Level is determined and adjusted based on successful reporting and performance on selected PCPM Track 2 Clinical Quality Measure Set.
2. Cost of Care Incentive Payment:
    a. Awarded PCPCH clinics will be eligible to receive and maintain a Cost of Care Incentive Payment based on performance on specified Clinical Cost of Care Measure.
3. Reporting deliverable deadlines are specified in Table 6.

Deliverable Schedules & Program Model

Table 5: PCPM Application and LOA Schedule – Track 2

APM Program	Application Deadline	LOA Deadline	LOA Effective Dates
All Regions PCPM Track 2	February 28, 2019	May 31, 2019	July 1, 2019 – June 30, 2020

Table 6: PCPM Reporting and Payment Adjustment Schedule – Track 2

LOA Effective Dates	Data Submission Deadline	Reporting Period	Payment Adjustment Date
All Regions PCPM Track 2 July 1, 2019 – June 30, 2020	August 31, 2019 **RY-2019-1**	**R-12**: Jul 01, 2018 – Jun 30, 2019 **CY**: Jan 01, 2019 – Jun 30, 2019	December 2019
	February 28, 2020 **RY-2019-2**	**R-12**: Jan 01, 2019 – Dec 31, 2019 **CY**: Jan 01, 2019 – Dec 31, 2019	June 2020

**RY = Reporting Year, -1 references 1st half of calendar year, -2 references full calendar year*

Table 7: PCPM Track 2 Program Model

	Clinical Quality Incentive Payment Only	*Meets* Cost of Care Incentive Payment Target - $1.50 PMPM
Payment Level 0		
Meet program targets on **0-5** Clinical Quality Measures	$0.00 PMPM	$1.50 PMPM
Payment Level 1		
Meet program targets on **6-7** Clinical Quality Measures	$3.50 PMPM*	$5.00 PMPM*
Payment Level 2		
Meet program targets on **8-9** Clinical Quality measures	$6.50 PMPM*	$8.00 PMPM*
Payment Level 3		
Meet program targets on **10-12** Clinical Quality measures	$10.50 PMPM*	$12.00 PMPM*

**Actual Clinical Quality Incentive Payment PMPM rates may be risk-adjusted up or down from PCPM Track 2 Program Model PMPM rates in Table 7. The risk adjustment methodology is based on a combination of risk scores and rate codes used by OHA and CMS. This method uses both the Chronic Illness & Disability Payment System (CDPS) and Hierarchical Condition Category (HCC) risk models.*

Quality Measure Set Selection

1. Clinic selects measure set most appropriate for each PCPCH population:
    a. Internal Medicine, Family Practice, or Pediatric.
    b. Clinics are responsible for ensuring EMR capability to extract data to Quality Measure specifications.
2. Quality Measures that include fewer than 30 CareOregon members in the denominator using aggregated Provider system data, must be substituted at the time of PCPM application.
    a. Quality Measures with fewer than 30 CareOregon members in the denominator will be considered "not met" during performance evaluation.
    b. Clinics are responsible for identifying Quality Measure substitutions at the time of PCPM Application.

Quality Measure Substitution

Quality Measures that include fewer than 30 CareOregon members in the denominator using aggregated Provider system data, must be substituted at the time of PCPM application.

1. Substitute Quality Measures must be selected from the PCPM Track 2 Measure Set.
2. If clinic does not meet denominator specifications for any PCPM Track 2 Measure, substitute Quality Measures must be selected from the PCPM Track 1 Measure Set.
3. If clinic does not meet denominator specifications for any PCPM Track 1 Measure, substitute measures may be selected as agreed upon with CareOregon.
4. All clinical quality measure substitutions must be identified and finalized prior to the execution of the PCPM Letter of Agreement.
5. **Clinics are responsible for identifying Quality Measure substitutions at the time of PCPM Application.**
6. A maximum of three (3) total Quality Measures may be substituted.
7. Quality Measure substitutions apply to all participating clinics reporting on the affected Quality Measure Set.
8. Quality Measures with fewer than 30 CareOregon members in the denominator will be considered "not met" during performance evaluation.
9. No changes are permitted to Quality Measures during the period of the Letter of Agreement.

Data Submission Requirements

1. For each measure indicated as "CareOregon Roster" in selected measure set, clinic must submit member-level data for all assigned CareOregon members (Oregon Health Plan and Medicare) where CareOregon holds the primary coverage.
    a. Data must be submitted via ShareFile – CareOregon Secure File Transfer Protocol (SFTP) site.
    b. Prior to data submission deadline, clinics will receive instructions to access CareOregon SFTP site.
    c. Clinics are responsible for ensuring access to SFTP prior to data submission deadline.
2. Data must be submitted to specifications as indicated on the PCPM Track 2 Measure Set.
3. For each measure indicated as "Claims" in selected measure set, CareOregon determines performance using claims data. Member-level claims data will be provided by CareOregon for validation.

PCPM Track 2 Clinical Quality Measure Set

To support the ongoing work of Coordinated Care Organizations and Medicare, these measures are aligned with both the State and Federal priority metrics.

PCPM Track 2 Quality Measures	Type	Specification	Measurement Period	RY2019-1 Target* Due 8/31/19	RY2019-2 Target* Due 2/29/20	FP	IM	PEDS
Adolescent Well Care Visits	Claims	CCO Incentive	Calendar Year	25.7%	55.8%	X	X	X
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Claims	NQF 1516	Calendar Year	31.2%	68.0%			X
Breast Cancer Screening	Claims	NQF 2372	Calendar Year	31.2%	68.0%		X	
Care for the Older Adults: Functional Status	Claims	HEDIS	Calendar Year	11.5%	25.0%		X	
Childhood Immunization Status (Combo 2)	Roster	CCO Incentive	Calendar Year	35.2%	76.7%	X		X
Cigarette Smoking Prevalence (start at 13 y/o)	Roster	CCO Incentive	Rolling 12	25.0%	25.0%	X	X	X
Colorectal Cancer Screening	Roster	CCO Incentive	Calendar Year	26.5%	57.8%	X	X	
Controlling Blood Pressure	Roster	CCO Incentive	Rolling 12	72.5%	72.5%	X	X	
Developmental Screening	Claims	CCO Incentive	Calendar Year	29.8%	65.1%	X		X
Diabetes: Eye Exam	Roster	NQF 0055	Calendar Year	34.2%	74.6%	X	X	
Diabetes: Hemoglobin A1c Poor Control	Roster	CCO Incentive	Rolling 12	20.6%	20.6%	X	X	
Diabetes: Medical Attention for Nephropathy	Claims	NQF 0062	Calendar Year	45.1%	98.5%	X	X	
Effective Contraception Use	Claims	CCO Incentive	Calendar Year	21.8%	50.2%	X	X	
Effective Contraception Use (Peds Clinic)	Claims	CCO Incentive	Calendar Year	11.0%	24.0%			X
Empanelment	Roster	PCPCH 4 A.0	Rolling 12	90.0%	90.0%	X	X	X
HPV for Adolescents	Roster	NQF 1959	Calendar Year	21.3%	46.4%			X
Immunizations for Adolescents	Roster	NQF 1407	Calendar Year	32.1%	70.0%			X
Screening for Depression and Follow-up Plan	Roster	CCO Incentive	Rolling 12	Report only	Report only	X	X	X
WCV In First 15 Months of Life	Claims	NQF 1392	Calendar Year	32.1%	70.0%			X
Weight Assessment & Follow Up	Roster	CCO Incentive	Rolling 12	32.7%	32.7%			X

**RY = Reporting Year, -1 references 1st half of calendar year, -2 references full calendar year.*

PCPM Track 2 Cost of Care Measure

PCPM Track 2 Cost of Care Measure	Type	Measurement Period	RY2019-1 Target* Due 8/31/19	RY2019-2 Target* Due 2/29/20	IM	FP	PEDS
ED & Inpatient Admissions for Ambulatory Care Sensitive Conditions (ACSCs)	Claims	Rolling-12	1.5% reduction	3% reduction	X	X	
Qualitative Reporting – TBD	N/A	TBD	N/A	N/A			X

**RY = Reporting Year, -1 references 1st half of calendar year, -2 references full calendar year.*

Table 8: Example of Rolling 12-month Methodology

Reporting Month	Rolling 12-Month Reporting Period
July 2019	August 1, 2018 – July 31, 2019
August 2019	September 1, 2018 – August 31, 2019
September 2019	October 1, 2018 – September 30, 2019

Cost of Care Measure Specifications

Inpatient and Emergency Department Utilization for Ambulatory Care Sensitive Conditions

Description

The Cost of Care incentive payment is based on a composite measure including inpatient admissions and emergency department visits per 1,000 member months for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, dehydration, bacterial pneumonia, or urinary tract infection. Numerator

Discharges and emergency department visits that meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQI):

PQI #1 Diabetes Short-Term Complications Admission Rate
PQI #3 Diabetes Long-Term Complications Admission Rate
PQI #5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
PQI #7 Hypertension Admission Rate
PQI #8 Heart Failure Admission Rate
PQI #10 Dehydration Admission Rate
PQI #11 Bacterial Pneumonia Admission Rate
PQI #12 Urinary Tract Infection Admission Rate
PQI #14 Uncontrolled Diabetes Admission Rate
PQI #15 Asthma in Younger Adults Admission Rate
PQI #16 Lower-Extremity Amputation among Patients with Diabetes Rate

More information about the PQIs can be found here:
http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v70.aspx

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator. Each visit to an ED for one of the above PQIs is included in the numerator. Multiple ED visits on the same date of service are counted as one visit. Emergency Department visits are specified by the codes identified in the OHA ED Utilization specifications found here:
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/Ambulatory-Care-Outpatient-ED-2018.pdf

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the codes in the above specifications.

Denominator

Member months for all CO assigned population aged 19 and older

Data elements required denominator: 1,000 Member Months